STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGUALTION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 90646-001**
v

Blue Care Network of Michigan
Respondent

_____/

Issued and entered
this 18th day of August 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On June 30, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. After an assessment of the material submitted, the Commissioner accepted the request on July 7, 2008.

The Petitioner is a member of Blue Care Network of Michigan (BCN), a health maintenance organization (HMO). The issue in this matter can be resolved by analyzing the BCN 5 certificate of coverage (the certificate), the contract that defines the Petitioner's health care benefits. It is not necessary to obtain a medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II
FACTUAL BACKGROUND

The Petitioner was diagnosed with prostate cancer. From December 10, 2007, to January 30, 2008, he had brachytherapy treatment at XXXXX and the XXXXX Medical Center (XXXXX), both in XXXXX. (Brachytherapy is a form of radiotherapy where a radioactive source is placed inside or next to the area requiring treatment.) XXXXX, XXXXX, and their physicians are not in BCN's network of providers.

The Petitioner requested reimbursement for the treatment provided by these out-of-network providers. BCN denied payment and the Petitioner appealed. BCN maintained its denial, saying that treatment was available within the BCN network.

The Petitioner exhausted BCN's internal grievance process and received its final adverse determination dated May 15, 2008.

III
ISSUE

Did BCN properly deny Petitioner's request for reimbursement for services from out-of-network providers?

IV
ANALYSIS

PETITIONER'S ARGUMENT

The Petitioner argues that BCN should cover his brachytherapy at XXXXX and XXXXX because of their expertise. His primary care physician, Dr. XXXXX, supported this position. Dr. XXXXX wrote in part:

> [The Petitioner] has Stage I prostate cancer that has been classified as a type T1c tumor. After consulting with Dr. XXXXX, we have jointly recommended that [the Petitioner] have brachytherapy seed implants utilizing the physicians at the XXXXX and having the procedure completed at the XXXXX in XXXXX.

> We and [the Petitioner] believe that his procedure needs to be done at these facilities for two key reasons:
>
> - First, the survival of [the Petitioner] and the "quality of life" after the procedure is of utmost importance in having the procedure completed.
>
> - Second, [the Petitioner] has a right to maximize his medical options to find the best care for his cancer.
>
> The XXXXX and its physicians have extensive experience and the highest degree of success in performing the brachytherapy procedure. They have performed more than 10000 of these procedures and are currently performing 20 procedures per week. By way of reference, Dr. XXXXX performs between 10-15 brachytherapy procedures per year. The success rate at eliminating prostate cancer at the XXXXX is one of the highest in the country. XXXXX documents show that in nearly 95% of patients that they have treated using brachytherapy, there is no recurrence of cancer within 10 years. A 2001 study showed the average success rate for this procedure is 87%. The XXXXX reports a national average of 88%.

The Petitioner argues that he followed the BCN guidelines by using his network primary care physician and a network urologist -- both recommended that he be treated at XXXXX and XXXXX. The Petitioner therefore believes that BCN should cover the out-of-network services.

BLUE CARE NETWORK'S ARGUMENT

In its final adverse determination letter, BCN denied coverage because the treatment the Petitioner sought was available within its network and BCN had already denied prior authorization for the treatment from the out-of-network providers.

BCN based its decision on this provision in the certificate (page 16):

> **Section 2.01 Unauthorized and Out-of-Plan Services**
>
> Except for emergency care as specified in Section 1.05 of this booklet, health, medical and hospital services listed in this Certificate are covered **only** if they are:
> - Provided by a BCN-affiliated provider.
>
> - Preauthorized by BCN.

> Any other services will not be paid for by BCN either to the provider or to the member.

BCN says that the treatment was neither provided by a BCN-affiliated provider or authorized in advance and therefore is not covered.

COMMISSIONER'S REVIEW

The focus of this analysis is whether BCN properly denied the Petitioner authorization and coverage for care from out-of-network providers.

The Commissioner notes that according to the certificate, specific procedures must be followed when seeking a referral for out-of-network services. If a member does not receive authorization before receiving the services, there is no coverage. These requirements are consistent with managed care contracts. BCN, as an HMO, operates within a network of providers who sign contracts and agree to accept BCN's negotiated rates. A fundamental premise of an HMO is the centralization of health care delivery within its network of providers. If an HMO member uses an out-of-network provider when services from in-network providers are available, payment for the out-of-network services may be greatly reduced or even excluded entirely by the HMO.

In the Petitioner's case, he was denied prior authorization but elected to proceed with the treatment knowing that it had not been approved and would not be covered. On September 19, 2007, before the Petitioner was treated in XXXXX, BCN denied coverage, saying treatment for his condition was available from network providers. BCN advised the Petitioner that services were available at the XXXXX, the XXXXX, and the XXXXX, all affiliated providers that offer brachytherapy.

HMOs are required to contract with a sufficient number or type of participating providers to provide covered benefits. If they do not, they must allow their members to receive care from outside the HMO network at no greater cost than if the benefit were obtained from a network

provider. See MCL 500.3505. However, it does not appear from this record that the Petitioner sought an evaluation from a network oncologist before proceeding to XXXXX. The Petitioner must make an effort to seek medically necessary care from network providers before seeking care from non-network providers. The Commissioner cannot find from this record that the Petitioner fully used the resources available within the BCN network.

The Petitioner argues that the XXXXX and XXXXX have the highest degree of expertise for the treatment of his condition according to his primary care physician and his network urologist. The Commissioner notes that an argument could be made for nearly every surgical procedure that there are highly regarded providers somewhere in the country that might possess the "highest degree of expertise." These facilities and physicians, however, are not always affiliated with every HMO. Section 3507 of the Insurance Code of 1956, MCL 500.3507, only requires HMOs to provide and deliver "an acceptable quality of health care by qualified personnel."

The Commissioner finds that the Petitioner did not establish that treatment was not available within BCN's network and did not have prior authorization for treatment at XXXXX and XXXXX. Therefore, BCN's denial of coverage was consistent with the terms and conditions of the certificate and state law.

V
ORDER

The Commissioner upholds BCN's final adverse determination dated May 15, 2008. BCN is not required to provide coverage for the out-of-network services received from the XXXXX and the XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner

of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.